Shared Care Working Group Update

10th May 2012

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Introduction

- Tri-regional shared care document and special requirements form done and presented in Oct 2011 RTC
- Working group: discussed at Feb 2011 RTC Breakout group

- Phase 1 (today)
  - Launch RTC Special requirements template for use
  - Highlight the different ways to communicate special requirements between hospitals

- Phase 2; start early September
  - Audit any improvements and agree actions as required
  - Assess ability to link in special requirements with indication codes
  - Sharing of experience on implementation

Options for Communication between transfusion labs

1. Existing Tri-Regional Shared Care Document

- *Available from London RTC website (word doc)*

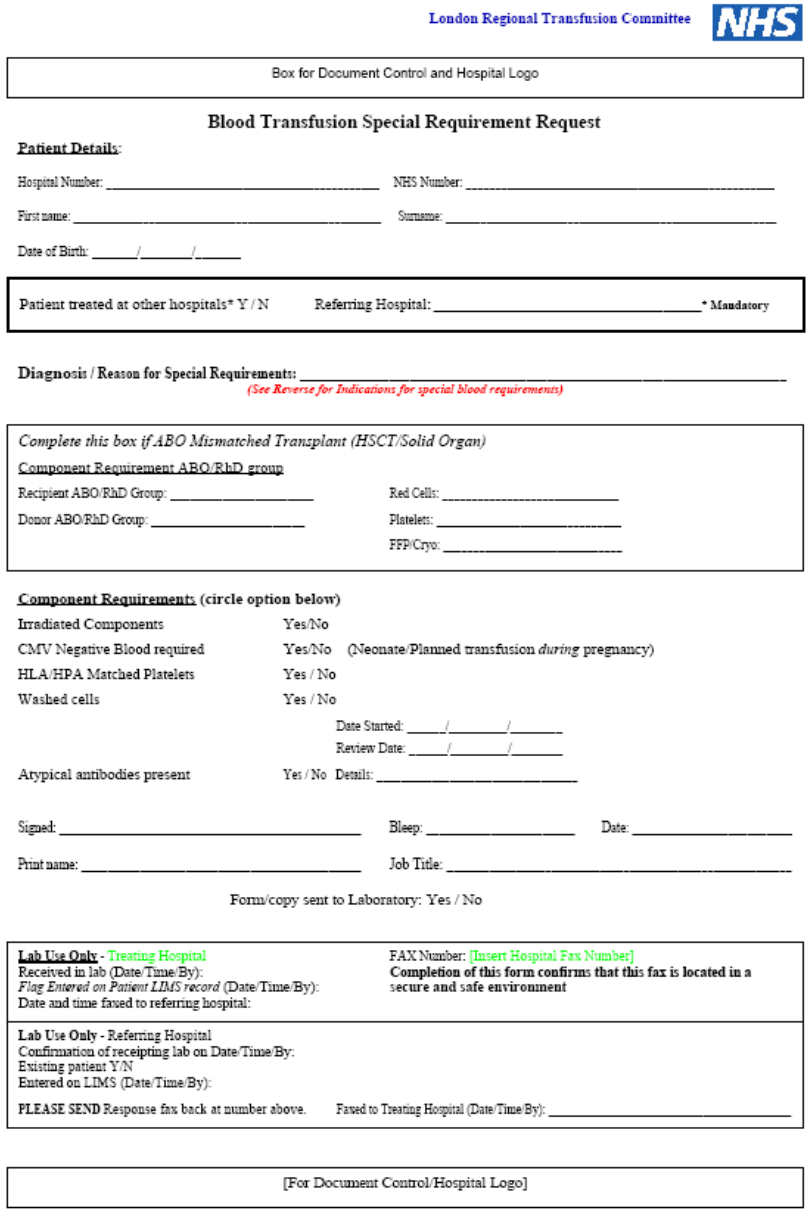
2. New RTC Special Requirements Template

- *London RTC website (word doc)*
- Adjustable for you own requirements
- Standard information

3. Existing local special requirements forms

- Adjusted to have key items to allow sharing of information

RTC Special Requirements Template



London Regional Transfusion Committee NHS

Box for Document Control and Hospital Logo

Blood Transfusion Special Requirement Request

Patient Details:

Hospital Number: _____ NHS Number: _____

First name: _____ Surname: _____

Date of Birth: _____/_____/_____

Patient treated at other hospitals* Y / N Referring Hospital: _____* Mandatory

Diagnosis / Reason for Special Requirements: _____

(See Reverse for Indications for special blood requirements)

Complete this box if ABO Mismatched Transplant (HSCT/Solid Organ)

Component Requirement ABO/RhD group

Recipient ABO/RhD Group: _____ Red Cells: _____

Donor ABO/RhD Group: _____ Platelets: _____

FFP/Cryo: _____

Component Requirements: (circle option below)

Irradiated Components Yes/No

CMV Negative Blood required Yes/No (Neonate/Planned transfusion *during* pregnancy)

HLA/HPA Matched Platelets Yes / No

Washed cells Yes / No

Date Started: _____/_____/_____

Review Date: _____/_____/_____

Atypical antibodies present Yes / No Details: _____

Signed: _____ Bleep: _____ Date: _____

Print name: _____ Job Title: _____

Form/copy sent to Laboratory: Yes / No

Lab Use Only - Treating Hospital
Received in lab (Date/Time/By):
Flag Entered on Patient LIMS record (Date/Time/By):
Date and time faxed to referring hospital:

FAX Number: [Insert Hospital Fax Number]
Completion of this form confirms that this fax is located in a secure and safe environment

Lab Use Only - Referring Hospital
Confirmation of receipting lab on Date/Time/By:
Existing patient Y/N
Entered on LIMS (Date/Time/By):

PLEASE SEND Response fax back at number above. Faxed to Treating Hospital (Date/Time/By): _____

[For Document Control/Hospital Logo]

1. Space for Hospital Header and Doc Control

2. Patient identification details

3. Identify if patient receiving care from another hospital

4. Details of special blood component requirements and requestor

5. Communication of Shared Care and Audit trial

6. Space for Hospital Footer and Doc Control

Change as you require – some examples

London Regional Transfusion Committee NHS

Logo St Elsewhere Hospital

Blood Transfusion Special Requirement Request

Patient Details:

Hospital Number: _____ NHS Number: _____

First name: _____ Surname: _____

Date of Birth: _____/_____/_____

Patient treated at other hospitals* Y / N Referring Hospital: _____ * Mandatory

IRRADIATED COMPONENTS: **YES / NO ***

If YES, give patient the NHSBT irradiated blood info leaflet and alert

☑ Tick as appropriate

- ☐ PBSC/ BM Transplant (Patient & Donors): From 7 days pre harvest or start of transplant conditioning
- ☐ Hodgkins disease: Irradiate at all stages regardless of treatment
- ☐ Treatment with purine analogues: e.g. Fludarabine, Deoxycoformycin (DFC)
- ☐ Granulocyte or Buffy Coat transfusions
- ☐ HLA selected platelets: (HLA platlets are automatically irradiated by the NHSBT)

CMV STATUS: **POSITIVE / NEGATIVE / NOT YET KNOWN ***

(Inform Lab as soon as possible of CMV status, and if CMV negative components are no longer required)

CMV NEGATIVE BLOOD REQUIRED: **YES / NO ***

- ☐ Pregnant Women
- ☐ Neonate

SINGLE DONOR PLATELTS REQUIRED: NO/YES*

WASHED PRODUCTS REQUIRED: **NO/YES *** **RBC/PLTS***

Signed: _____ Bleep: _____ Date: _____

Name of authorising clinician: _____ Role: _____

PLEASE FAX TO BLOOD TRANSFUSION (x84783) WHEN COMPLETED

PLACE ALERT STICKER ON PATIENT'S BLOOD PRESCRIPTION CHART

Lab Use Only – St Elsewhere Hospital FAX Number: 0203 123 8451
Received in lab (Date/Time/By):
Flag Entered on Patient LIMS record (Date/Time/By):
Date and time faxed to referring hospital:

Lab Use Only - Referring Hospital
Confirmation of receipting lab on Date/Time/By:
Existing patient Y/N
Entered on LIMS (Date/Time/By):
PLEASE SEND Response fax back at number above. Faxed to Treating Hospital (Date/Time/By): _____

~~Document Control Number: Docum3nt C0ntr0l 12345~~ ~~Version: 1~~
Date 10/03/12 Author: Jack Jones

Document Control Number: Docum3nt C0ntr0l 12345 Version: 1
Date 10/03/12 Author: Jack Jones

St Elsewhere Hospital

Blood Transfusion Special Requirement Request

FILE FORM AT FRONT OF PATIENT NOTES
A COPY OF THIS FORM MUST BE SENT TO BLOOD TRANSFUSION

Patient Details:

Hospital Number: _____ NHS Number: _____

First name: _____ Surname: _____

Date of Birth: _____/_____/_____

Patient treated at other hospitals* Y / N
Referring Hospital: _____ * **Mandatory**

Diagnosis / Reason for Special Requirements: _____
(See Reverse for Indications for special blood requirements)

	(Circle requirement)
CMV Negative required	YES / NO
Irradiated required	YES / NO
HLA Matched Platelets	YES / NO
Washed red cells (Consultant request only)	YES / NO

Atypical antibodies _____

Review date: _____ / Indefinite

Signed: _____ Bleep: _____ Date: _____

Print name: _____
Status (SpR / Consultant / Tx co-ordinator): _____

Lab Use Only – St Elsewhere Hospital FAX Number: 0203 123 8451
Received in lab (Date/Time/By):
Flag Entered on Patient LIMS record (Date/Time/By):
Date and time faxed to referring hospital:

Lab Use Only - Referring Hospital
Confirmation of receipting lab on Date/Time/By:
Existing patient Y/N
Entered on LIMS (Date/Time/By):
PLEASE SEND Response fax back at number above. Faxed to Treating Hospital (Date/Time/By): _____

SAMPLE SAMPLE

Problems for communication.

Fax numbers

- **Website access**

Caldicott guidelines

- **Patient information**

Management of duplicate records

- **Shared care**

Other barriers

Point of completion of tri-regional shared care form

- No control within hospital how this worked.

Receipt of form at hospital where no existing record exists

- How to register the patient into the system.
  - Out of remit for this working group

Doctors education

- How do doctors know what to request

[Indications to be changed as per hospital requirements]

Indications for Irradiated Cellular blood components

Transfusion from first- or second-degree relatives

Any granulocyte transfusion for any recipient

HLA-selected platelet units

Patients receiving purine analogues (fludarabine, cladribine, deoxcoformycin)

Intrauterine transfusion (IUT)

Exchange Transfusion

Red cell or platelet transfusion in neonates – if there has been a previous IUT

All recipients of allogeneic haemopoietic stem cell (HSC) grafts

Blood transfused to allogeneic HSC donors before or during the harvest of their HSC

Patients who will have autologous HSC graft:
- Any transfusion within 7 days of the collection of their HSC
- Any transfusion from the start of conditioning therapy until
  - 3 months post transplant
  - 6 months post transplant if conditioning TBI has been given

Hodgkin's disease, at all stages of the disease

Congenital immunodeficiency with defective cell-mediated immunity (e.g. SCID, Di George syndrome, Wiskott Aldrich syndrome, purine nucleoside deficiency, reticular dysgenesis, ADA, Ataxia telangectasia, chronic mucosal candidasis, MHC class 1 or 2 deficiency)

Indications for CMV-antibody-negative components

Granulocyte units

Intrauterine transfusion (IUT)

Pregnant women who require repeat elective transfusions during course of pregnancy (not labour and delivery)

Indications for HLA/HPA Matched Platelets

Immune Platelet Refractioness

Positive screen for HLA class 1 or HPA antibodies or both

Refractioness to an ABO compatible platelet concentrates on two occasions

Atypical Antibodies Present

History of blood Group Antibodies

Haemoglobinopathy Patient (Sickle Cell Disease, Thalassemia)

Possible new barrier?

SaBTO CMV recommendation !!!

What do we do if a hospital decides not to follow the new recommendations?

What next

- Please use the RTC special requirements template or adjust your local special requirements form to enable the information to be shared. All forms and fax numbers will be on the RTC website

Phase 2:

- Audit to assess impact of special requirements form on shared care later this year with action depending on results
- Assess the ability to link in special requirement reasons with indication codes
- Sharing experience of implementation at future RTCs